Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 31, Aug 1, 2, 3, 7, 10, Sep 4, 5, 6, 10, 11, 12, Oct 9, 10, 2012	2012_027192_0037	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

Long-Term Care Home/Foyer de soins de longue durée

DOVER CLIFFS
501 St George Street, P.O. BOX 430, Port Dover, ON, N0A-1N0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DEBORA SAVILLE (192), CAROL POLCZ (156), TAMMY SZYMANOWSKI (165), YVONNE WALTON (169) BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Director of Care, Wound Care Nurse, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Registered Dietitian, Food Services Supervisor, Dietary Aides, Recreation Aide, Corporate Nursing Practices Co-ordinator, Office Manager, maintenance staff, residents and family members of residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas, and care provided to the residents, reviewed medical records including the plan of care for identified residents, reviewed policy and procedures of the home and observed general maintenance, cleaning and condition of the home.

RQI - H-001323-12

This inspection was conducted concurrently with the following inspections:
CIS Inspection 2012_027192_0038 (H-001291-12, H-001343-12, H-00947-11, H-001959-11)
Complaint Inspection 2012_027192_0039 (H-001579-11, H-000328-12)
Environmental Inspection 2012_072120_0055 (H-001371-12)

Areas of non-compliance identified during inspections 2012_027192_0038 and 2012_027192_0039 are included in this inspection report.

The following Inspection Protocols were used during this inspection:

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following subsections:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a skin and wound care program is implemented in the home that promotes skin integrity, prevents the development of wounds and pressure ulcers, and provides effective skin and wound care interventions. [r. 48. (1) 2.]

a) The home acknowledges, during interview, that a corporate skin and wound care program that includes development of internal interdisciplinary skin and wound care team, the use of assessment tools and wound care protocols, wound management algorithms and quality improvement tools for monitoring and reporting is available for use in the home.

b) Interview confirms that the home does not have an interdisciplinary wound care team.

c) Interview confirms the physiotherapist is not included in referrals for residents with altered skin integrity. Two of four residents interviewed with ongoing wounds indicated that they were experiencing pain in the area of altered skin integrity. The use of pressure relieving devices within their chairs or on their beds were not present. Interview with the Physiotherapy Aide confirms that residents 778 and 1003 who have altered skin integrity and complain of pressure related pain have not been referred to physiotherapy related to these concerns.

d) Interview confirms that an informal process is used to communicate with the Registered Dietitian related to the presence of altered skin integrity for residents of the home. Assessment by the dietitian is not consistent for all residents with altered skin integrity. 3 of 4 residents reviewed did not have nutritional assessments that included the presence of altered skin integrity.

e) Interview with the Wound Care Nurse for the home indicates that protocols related to wounds care are available, but it is noted that 4 of 4 wounds reviewed are treated with proviodine and no wound covering regardless of the stage of the wound which is not consistent with wound care protocols provided within the corporate program.

f) Dry dressing supplies are available within the home. Interview with the Director of Care confirms that wound care supplies for moist healing are not frequently used within the home.

g) A review of quality improvement statistics gathered by the home for the month of June does not include all residents with stageable pressure wounds.

h) During interview with the Director of Care and wound care nurse, neither were able to identify the prevalence of pressure ulcers within the current population. Interview with Personal Support Workers indicates that "a lot" of the resident's of the home have open pressure wounds. Record review identified 28 of 35 residents on the first floor had documented altered skin integrity through the month of July 2012

i) The home was unable to provide information related to the prevalence of wounds or the effectiveness of the wound care program in the home.

j) Interview with the Director of Care confirms that residents of the home are not referred to specialized resources related to wound care.

k) Policy related to skin and wound care and provided by the home was not complied with:

Weekly assessments by a member of the registered nursing staff:
Interview and record review confirm that weekly wound assessments for three stageable wounds were not completed for resident 857 on specified dates in 2012. Resident 770 had a stagable wound that was not assessed for specified weeks in 2012.

Assessment and documentation of altered skin integrity identified by unregulated care providers (UCP):
Documentation review identified that UCP consistently recorded changes in the residents skin status on the Bath Record/Skin Checklist but this information was not consistently communicated to registered staff. Interview with both UCP staff and registered staff identified that registered staff are expected to review the Bath Record/Skin Checklist daily and assess identified changes in skin integrity. Documentation review of the Bath Record/Skin Checklist for the first floor

for the month of July 2012 identified that changes in the condition of skin for residents 816, 1011, 787, 849, 1013, 1014, 778, 822 and 790 did not have a documented assessment of the identified change in skin condition. Registered staff interviewed confirmed that not all changes in skin condition were assessed when they were identified. (192)

Resident's with altered skin integrity are assessed by a member of the registered nursing staff on return from hospital: Resident 787 was in hospital for six days and returned to the home in 2012. The resident's plan of care identified potential altered skin integrity however, the registered nurse confirmed that no skin assessment was completed on return from hospital. Resident 817 who had altered skin integrity at the time of hospitalization returned from hospital in 2012. Interview and documentation review confirmed that no skin assessment was completed by registered staff on return from hospital.

The home has not implemented the skin and wound care program available to them through corporate resources. (192)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care
Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident. [s. 6. (1) (a)]

a) Residents 857, 788 and 787 did not have a plan of care that set out the planned care for the residents related to hygiene and grooming. (165)

b) Resident 783 was identified by registered staff as being at actual risk for heat related illness and in 2012 the indoor humidex values were 30-33. The July 2012 medication review for the resident indicated staff to encourage fluids at least 1500ml/day – push fluids 1250-1375/day). The resident was consuming below their fluid goal for thirteen consecutive days in 2012 however; there was no plan of care developed to address the resident's heat related and hydration risks. (165)

c) A psychiatric consultation in resident 4001's clinical record suggested for staff to offer the resident drinks. The resident was identified by registered staff as being at actual risk for heat related illness and the hot weather related illness risk factor assessment completed in 2012 indicated for the home to implement care planning interventions. In 2012 the indoor humidex values in the home were 30-33. Registered staff confirmed that there was no plan of care developed to address the resident's heat related risks including hydration despite being identified by staff. (165)

d) Resident 4000 was admitted to the home in 2012. The minimum data set (MDS) provided on admission indicated that the resident ate one or fewer meals and consumed insufficient fluids. The resident had developed a urinary tract infection and the resident was identified by registered staff as being at actual risk for heat related illness. In 2012 the indoor humidex values were 30-33. Registered staff confirmed that there was no plan of care developed to address the resident's heat related and hydration risks despite being identified. (165)

e) The plan of care for resident 817 did not include the resident's needs related to bathing. Staff interviewed indicated that resident 817 had very sensitive skin and that even drying her with a towel could cause pain - this information is not included in the plan of care. (192)

f) Physician notes in 2012 indicated that resident 840 had chronic constipation. The minimum data set (MDS) completed on a specified date in 2012 for significant change in health condition identified constipation as a trigger and flow sheets indicated the resident had only five bowel movements during a specified period in 2012 however; there was no plan of care related to constipation that set out the planned care for the resident.

2. s. 6(7) was previously issued 2010/09/08 and 2010/10/18 as a WN and VPC.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

a) Resident 776 sustained a fall in 2011, resulting in injury. The resident was found on the floor, in the bathroom, by a staff member. No staff member was in attendance during toileting. The resident had demonstrated a change in condition and had fallen two days prior while self transferring. The plan of care in effect at the time indicated that the resident required one person physical assist in the bathroom. The Director of Care confirmed that care was not provided as set out in the plan of care. (192)

b) Resident 787's plan of care directed staff to notify the dietitian of any choking episodes immediately. The resident experienced choking episodes on three documented occasions in 2012 however, their was no referral or notification to the home's Registered Dietitian for reassessment. The food service supervisor confirmed their was no referral sent for any of the choking episodes. (165)

c) Resident 857's plan of care for constipation indicated that staff provide bowel medications as needed per protocol. The protocol directed staff to provide bowel medication on the third consecutive day of no bowel movement. The resident's daily flow sheet indicated the resident did not have a bowel movement during a specified period in 2012 however, the medication administration record indicated the resident was not offered a laxative until the fourth consecutive day without a bowel movement. The registered practical nurse confirmed that laxatives are provided on the

third consecutive day without a bowel movement however, this was not followed for this resident.

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

a) Resident 857 had their catheter discontinued by the physician in 2012 however, the resident's quarterly review assessment completed by a registered practical nurse indicated that the resident had an indwelling catheter which gets changed monthly. Another registered practical nurse confirmed that the catheter was discontinued and the resident had not required the catheter since it was discontinued in 2012. (165)

b) Resident 817 had been treated for ongoing pain. Medication treatment was stopped in 2012. Minimum Data Set (MDS) assessments completed in 2012 indicate the resident had pain daily. Resident interview indicates that pain is controlled. Documentation review indicated that the resident has had no documented complaints of pain over a specified period in 2012. Personal Support Worker interviewed indicated the resident complains of pain 3-5 times per week.

Assessments completed by the Resident Assessment Instrument (RAI) Coordinator, physician and registered staff are inconsistent.

4. The licensee failed to ensure that if the resident is being reassessed and the plan of care is being reviewed and revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care. [s. 6. (11) (b)]

a) Resident 817 sustained falls on on two specified dates in 2012. The resident was assessed post fall, but when the plan of care was reviewed, the plan of care was not updated to include different approaches. Resident 817 sustained a subsequent fall in 2012. (192)

b) Resident 778 has a plan of care related to potential skin breakdown that was initiated in 2010 and reviewed in 2011 and 2012. Two interventions were added to the plan of care in 2011, including specific requests made by the Power of Attorney. On a specified date in 2012, resident 778 developed an area of altered skin integrity. As of 2011 the plan of care has not been revised to include different approaches for pressure reduction. Interview confirms that the plan of care has not been revised with different approaches.

5. s. 6(10)b was previously issued on 2010/09/08 as a WN.

The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

a) Resident 787 was in hospital for six days and returned to the home in 2012 with a catheter. Physician's notes dated in 2012 indicated the resident had a urinary tract infection however; the resident's plan of care was not reviewed and revised when the resident's care needs changed. (165)

b) The plan of care for resident 776 indicates under mobility that they are able to walk independently in the corridor with limited assistance, are able to walk independently in the room, and is independent for bed mobility. Interview and documentation review confirm that the resident has not walked independently since fracturing a hip in 2011. Interview and observation identify that the resident is dependent on a wheelchair for mobility within the home. The use of a wheelchair is not addressed in the plan of care. Over the course of this inspection the resident was observed daily - the resident was not observed walking independently.
Assessments completed in 2012 indicated the resident required extensive assistance of two staff for mobility in the bed and room and total assistance of one staff for mobility in the home. Interview with the Personal Support Worker indicates that the resident required the assistance of one or two staff for all transfers, that the resident used a wheelchair and was dependent on staff for mobility in the wheelchair. (192)

c) Resident 857 had their catheter discontinued by the physician in 2012 however, the current plan of care for the resident indicated a catheter was still used; staff are required to change the catheter monthly, provide catheter care each shift and document intake and output each shift. The registered practical nurse confirmed that the resident no longer used a catheter. (165)

d) Treatment records indicated that resident 857's altered skin integrity are no longer a concern however, the resident's plan of care indicated that the resident has altered skin integrity with interventions in place. The registered practical nurse confirmed that the resident's altered skin integrity is currently healed however, the plan of care was not reviewed and revised. (165)

e) Resident's 787's continence assessment completed in 2012 for a significant change in resident status indicated that the resident was frequently incontinent and that after the removal of the catheter in 2012 the resident had been incontinent. The resident confirmed that he was incontinent however the resident's plan of care to maintain bladder and bowel continence indicated that the resident is usually continent and occasionally incontinent.

f) The clinical notes identify resident 792 was receiving palliative care in 2012. The current plan of care directed staff to dress the resident daily and the staff confirmed they do not dress the resident anymore as the resident is in bed all the time and wears a hospital gown for comfort. The plan of care identified the resident participates extensively in care, however the nursing staff confirmed the resident was unable to participate in any of the care. The plan of care directed staff to offer thin water for drinking, however the physician had ordered all fluids to be of a nectar consistency. The plan of care does not direct care as per the wishes of the family. The plan of care did not identify the resident's pain management program and it was noted the resident received narcotic analgesics and is on a therapeutic surface to assist with pain management. (169)

g) Resident 817 had sustained frequent changes to skin integrity in 2012. The plan of care had not been updated to include the presence of open areas related to pressure and skin tears. Resident 817 was identified to be at risk of skin breakdown however the presence of multiple open areas were not addressed within the plan of care. The plan of care indicates the resident had altered skin integrity. Interview with the resident and staff confirm that there is not altered skin integrity.

6. The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

Personal Support Worker (PSW) staff who provide direct care to resident 219 were unaware of the contents of the plan of care. The resident was identified as high risk for falls based on a 2012 assessment. One intervention in the plan of care stated to keep the bed in the lowest position while in bed. On specified dates in 2012 resident 219 was observed in bed and the bed was at staff level height, not in the lowest position. Three PSW staff confirmed they do not put the bed in the lowest position while the resident is in bed, nor were they aware of the new directive.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there is a written plan of care; that staff and others involved in different aspects of care collaborate with each other; and that the plan of care is reviewed and revised when care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (1) Every licensee of a long-term care home shall ensure that the infection prevention and control program required under subsection 86 (1) of the Act complies with the requirements of this section. O. Reg. 79/10, s. 229 (1).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols; and
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the infection prevention and control program required under section 86(1) of the Act complies with the requirement of this section. [r. 229(1)]

The home is non-compliant with sections 229 (3)(a), (b), (c); and 10(1), and (4) as outlined in evidence below.
2. The licensee failed to designate a staff member to co-ordinate the program who had education and experience in infection prevention and control practices, including: infectious diseases [r. 229(3)(a)]; cleaning and disinfection. [r. 229. (3) (b)]; data collection and trend analysis. [r. 229. (3) (c)];

Interview with the Director of Care confirmed that the designated Infection Prevention and Control Co-ordinator does not have education and experience in infection prevention and control practices including cleaning and disinfection. (120)

Interview with the Director of Care and Executive Director confirm that the Infection Prevention and Control co-ordinator does not have education and experience in infection prevention and control practices including, infectious diseases, data collection and trend analysis. (169)

Inspection 2012_072120-0055 (H-001371-12) conducted concurrently with this inspection includes findings related to improper cleaning and disinfection practices in the home.

3. The licensee failed to ensure staff are screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [r. 229. (10) 4.]

The Executive Director and Director of Care confirmed newly hired staff are not screened for tuberculosis.

4. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis (TB) within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [r. 229. (10) 1.]

a) Resident 2001 was admitted to the home and did not receive a TB skin test for a 5 months period and not within 14 days of admission. This was confirmed by the Registered Nurse, Director of Care and Executive Director.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to ensure the Infection prevention and Control program includes daily monitoring of infections in residents. [s. 86. (2) (a)]

The Infection Control Listing Report identified 21 residents with signs and symptoms of infection, however pharmacy reports indicated that 36 residents were prescribed antibiotics. The Director of Care and the Executive Director confirmed the inconsistency between the Infection Control Listing Report and number of confirmed antibiotics dispensed and that not all residents with signs and symptoms of infection had been included on the Infection Control Listing Report.

2. The licensee failed to ensure that there are measures in place to prevent the transmission of infections. [s. 86. (2) (b)]

a) Resident 281 uses a device during the day and another device at night. The resident shared a room with another ambulatory resident who shared the washroom. The used device was observed hanging from the only towel bar in the shared washroom. This towel bar was not labeled for resident 281. Also, there was a visibly soiled device sitting on the back of the toilet. The Personal Support Worker (PSW) was asked about the process for cleaning and disinfecting the device and replied she didn't know. She stated she sometimes takes it to the clean utility room and rinses it out. The PSW asked the Director of Care for direction however she was also unclear of the process for cleaning and disinfection of the device. The home was not using measures to prevent the transmission of infection and the care of specified equipment therefore putting the resident at risk of infection. (169)

b) Resident 1003 has an area of altered skin integrity that was swabbed on in 2012 and identified to be positive for Methicillin Resistant Staphylococcus Aureus (MRSA) and Pseudomonas. Staff interview confirmed that staff were not aware of residents who are MRSA positive or with other wound infections. No signage is posted on the room to notify staff and visitors of the potential risk, or actions to take to minimize the risk of transmission of infections. Resident 1003 was observed to refuse to have a dressing covering an area of altered skin integrity that was positive for MRSA.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the infection prevention and control program includes daily monitoring to detect the presence of infection in residents of the long-term care home and measures to prevent the transmission of infections, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. 8(1)b was previously issued on 2011/02/14 as a WN.

The licensee failed to ensure that where the Act or this Regulation requires the licensee of the long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. [r. 8. (1)b]

A) The bowel protocol directs staff to provide bowel medication on the third consecutive day of no bowel movement and a suppository on the fourth consecutive day. The resident's daily flow sheet indicated that resident 840 did not have a bowel movement during specified periods in 2012 however, the medication administration record indicated the resident was not offered a laxative on these occasions. The registered practical nurse confirmed that laxatives were not provided to the resident despite the resident having no bowel movement for five consecutive days on these occasions. (165)

The home's bowel protocol and standing orders indicate that for a resident on lactulose with loose stools, staff should hold the lactulose for 24 hours then resume order.

Bowel records for resident 787 indicated that the resident experienced loose bowel movements on specified dates in 2012 however, the medication administration record indicated the resident continued to receive medications that would affect the consistency of their bowel movements. The Registered Practical Nurse (RPN) confirmed that the resident was receiving the medications despite documentation on the bowel records that indicated loose bowel movements. The RPN confirmed that her practice would be to hold the medications when bowel movements are loose. (165)

B) The policy titled "Management of Methicillin Resistant Staphylococcus Aureus (MRSA)(LTC-1-600).

"5. The registered staff will initiate Contact Precautions in addition to Routine Practices for those Residents with the following conditions:
- draining infected wounds in which drainage cannot be contained by a dressing."

i) Resident 1003 has a stageanle wound that is positive for MRSA. The wound was observed to be moist, drainage is noted on the mattress surface, the resident's clothing is moist with drainage from the wound. Staff interviewed were unaware of the need for contact precautions, no signage was posted to alert staff of the need for contact precautions.

" 11.1 Document the Resident's MRSA status on his/her health record, if the resident is MRSA positive (Colonized or Infected). Send the completed transfer form with the Resident to the receiving facility."

i) Resident 1003 was transferred to hospital in 2012. Observation and interview confirms that no paperwork accompanied the resident on transfer. The ambulance and receiving facility were not notified of the MRSA status of the resident. (192)

C) The home's policy (LTC-N-60) titled Pain Assessment and Symptom Management - National Policy states:
"Pain Monitoring: If pain has been identified, a Pain Monitoring tool will be initiated for 72 hours.
1. Initiate Pain Monitoring Tool when: e) Pain medication is discontinued."

i) Resident 817 had pain and was treated with narcotic analgesic in 2012. On return from hospital, the narcotic analgesic was not restarted. Interview and documentation review indicate that no Pain Monitoring Tool was initiated when the narcotic analgesic was stopped on readmission to the home 2012. (192)

D) The home's policy LTC-H-340 related to resident's weight and height was not complied with. The procedure indicated that "residents will be weighed monthly by staff and recorded on the resident's monthly weight chart tool or point of care on the resident's first bath day of each month. If a resident's weight loss or gain is 2.0 kg or greater from preceding month, a reweigh will be completed immediately."

i) The home's monthly weight chart tool and point of care indicated that resident 788 did not have a monthly weight until a specified date in 2012 and reweighs were not taken and recorded for the months of February, April, May and July 2012

when the resident's weight difference was greater than 2.0kg from the preceding month. (165)

ii) The home's monthly weight chart tool and point of care indicate that resident 857's weight was not taken and recorded for a specified month in 2012 and reweighs were not recorded for the months of February and March 2012 when the residents weight difference was greater than 2.0kg from the preceding month. The home's director of care confirmed that the weight and reweighs were not taken and recorded as required. (165)

E) The home did not comply with their readmission from hospital policy LTC-A-100 when resident 787 returned from hospital on two occasions in 2012. The procedure indicated that the Registered Nurse (RN)/Registered Practical Nurse (RPN) on the shift the resident returned from hospital would complete a full assessment and document on the resident's health record. The assessment would include vital signs, disease specific monitoring, and general safety precautions. The resident would be assessed by the RN/RPN on three shifts following readmission, noting the vital signs, disease specific assessment, and general safety precautions. The physician would be notified of the readmission and orders obtained for medication, diet and treatments.

The resident's clinical health record indicated that a full assessment including vital signs, disease specific monitoring, and general safety precautions was not completed on the shift the resident returned from hospital in 2012 and the registered practical nurse confirmed there was no full assessment and assessments on the three shifts following readmission including the residents vitals. There was no physician order obtained for the resident's treatments and there was no physicians order obtained for a diet when the resident returned from hospital in 2012. (165)

F) The home's policy LTC-N-75 titled Fall Interventions Risk Management Program revised September 2011 indicated that:

Falls include all Residents found on the floor.
When a fall occurs a multidiciplinary progress note (MDPN) will be completed. If the site is not completing MDPN electronically, the "Resident Fall Documentation Form" will be used to document resident post fall.

i) The home was not using MDPN on in 2011 when resident 776 was found sitting on the floor. No "Resident Fall Documentation Form" could be provided by the home. The resident was not assessed and no new interventions were initiated as a result of the fall. Resident 776 fell two days later in 2011 and sustained an injury. (192)

G) On July 25, 2012, the blue plastic coffee mugs, stored in the kitchen, were observed to be heavily stained from tea and coffee. A review of the dishwashing process was conducted and determined that the machine does not remove the stains. Posted on the kitchen wall near the entrance was a procedure for kitchen staff to "bleach glasses and cups every 1st Friday and 3rd Friday of the month". July 20, 2012 would have been the 3rd Friday of the month and staff would have been required to bleach the mugs. Discussion with staff of the home indicated that bleaching of the mugs was not consistently completed.

H) The home's "Hot Weather Related Illness Protocol" LTC-N-80, dated August 2006 for Heightened Heat Stress Alert (heat index between 30 and 39) indicated the following;

Internal Humidex value on July 17, 2012 at 1500 hours in the first floor lounge was 41 (temperature - 33 degrees celcius, humidity 50%).

i) "Heat Alert notices will be posted in affected areas".
No heat alert notices were observed posted in affected areas.
Interview with the Executive Director confirmed that heat alert notices were not posted in the home.

ii) "Staff need to ensure they are recording shift pre-startup humidex values in tub rooms and home areas."
Staff have not been monitoring and documenting the internal air and humidity temperatures. The forms reviewed for both 1st and 2nd floors for the months of June and July were mostly blank. The staff are required to record temperatures, the humidity and a humidex value on 3 shifts each day. A total of only 7 shifts were recorded between July 1-17, 2012.

iii) "During a heat wave residents should be observed for symptoms of hot weather related illness and assessed each shift for signs of heat stroke."
Staff interviewed were unable to determine who was at high risk for hot weather related illness or signs and symptoms of hot weather related illness. There are no documented assessments completed each shift for signs of hot weather related illness or heat stroke.

iv) The home "will develop communication protocols to communicate hot weather action plan/contingency plan to residents, staff, volunteers, families and visitors as required".
Staff interview confirmed that no communication of the home's hot weather action plan had been made to staff, visitors or families.

v) "Residents, staff and volunteers will be educated on hot weather related illness, prevention and management annually."
Residents and volunteers have not been educated on hot weather related illness prevention. When registered and non-registered staff were interviewed, they were unaware of the need to keep windows closed and to monitor and document air and humidity values.

vi) "All staff will work collaboratively to implement hot weather related strategies for resident care including, but not limited to, availability of cooling equipment/portable fans and reducing heat sources."
Cooling equipment was not available in the home and ready for use. Additional units were purchased on July 17, 2012. However, the units failed to work as the home's electrical system was not able to handle the additional voltage capacity. The home did not take measures to reduce heat sources. The policy refers to the Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes. In the guidelines, additional environmental controls are listed such as closing windows, installing window blinds or roller shades on windows with direct sunlight, conducting an electrical capacity assessment, installing radiant barriers in the attic, replacing typical incandescent light bulbs with compact fluorescent bulbs, tempering or shutting down the fresh air intake supply to reduce humidity levels of make up air, insulating pipes to prevent condensation or to reduce heat emissions and ensuring adequate attic/roof ventilation and insulation. Interview and observation confirmed that the above strategies had not been implemented. (120)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the skin and wound program includes goals and objectives, protocols for referral of residents to specialized resources where required. [r. 30. (1) 1]

a) Documentation review and interview confirm that there are no written goals and objectives for the Skin and Wound program.

b) Interview with the Director of Care confirms that residents with complex or non-healing wounds are not consistently referred to specialized resources where required.

2. The licensee failed to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that the program is evaluated and updated at least annually in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices. [r. 30. (1) 3]

Documentation review and interview confirm that the following programs were not evaluated and updated at least annually in accordance with evidenced-based practices:

Nursing and personal care, recreation and social activities, dietary services, medical services, information and referral services, religious and spiritual practices, accommodation services, and the volunteer program.

3. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. [r. 30. (2)]

a) Resident 806 was observed to have sustained an injury in 2012. The Executive Director was made aware of the presence of the injury and an investigation was initiated. Interview with the Executive Director following investigation into the injury identified that registered staff were made aware of the injury one day prior to the Executive Director being made aware. Resident 806 was noted to be complaining of discomfort in the area of the injury. Documentation review found that the presence of an injury from an unknown cause was not documented when staff became aware of the injury. (192)

b) Resident 788's plan of care indicated the resident was receiving a high energy high protein drink three times a day between meals. Food and fluid records for July 2012 do not include documentation of the resident's response to the intervention. The resident confirmed that they had been refusing the high energy high protein intervention for most of the month however this was not documented. The home's dietitian confirmed that documentation of the resident's high energy high protein drink was not always completed and available for assessment. (165)

c) Resident 857's bathing record did not include documentation that the resident received a bath on three occasions in 2012. A personal support worker confirmed that documentation was incomplete for these dates.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there is a written description of the program that includes goals and objectives, that each program is evaluated and updated at least annually and that there is a written record relating to each evaluation, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Related to H-001579-11
The licensee failed to ensure that supplies are readily available as required to treat pressure ulcers and promote healing. [r. 50. (2) (c)]

a) Resident 770 requires dressing changes three times each week, related to a stageable wound. Resident interview and documentation review identified that dressing supplies required for resident 770 were not available on specified dates in 2012. A dry dressing was applied and the wound treatment was completed as ordered when supplies where available in 2012. Resident interview indicates that this is the second time the home has been without supplies to complete the treatment as ordered.
Staff interview confirms that the home has run out of supplies for completion of the wound treatment as ordered.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that supplies are readily available as required to treat pressure ulcers and promote healing, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours include assessment, reassessments, interventions and documentation of the residents responses to the interventions. [r. 53. (4) (c)]

a) Resident 817 was identified in Minimum Data Set (MDS) assessments completed in 2012 to have responsive behaviours . Flow sheet documentation completed by the Personal Support Workers indicated that the resident demonstrated responsive behaviours in 2012. A review of documentation for a five month period in 2012 did not include documentation of responsive behaviours demonstrated by resident 817 or interventions used to manage those behaviours. The effectiveness of interventions is not assessed in the progress notes or the Resident Assessment Protocol (RAP) summary available for each of the MDS assessments.

2. The licensee failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible. [r. 53. (4) (b)]

a) Resident 817 was identified in Minimum Data Set (MDS) assessments completed in 2012 to demonstrate responsive behaviours daily. The plan of care for resident 817 available to all staff, did not include the presence of these identified behaviours or interventions to manage these behaviours when they are demonstrated.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours where possible and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. s. 19(1) was previously issued 2011/05/17 as a WN and VPC and on 2012/04/05 as a WN.

The licensee failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. [s. 19 (1)]

Related to H-00947-11 and H-001959-11
a) Interview and documentation review confirm that in 2011, resident 842 was struck by a staff member of the home. No physical injury was noted.

b) Interview and documentation review confirm that in 2011 resident 826 was injured by a co-resident of the home with known unpredictable responsive behaviours. Resident 826 was sent to hospital for assessment and immunization.

c) Interview and documentation review confirm that in 2012 resident 4000 was abused by a co-resident known to demonstrate unpredictable responsive behaviours. Resident 4000 sustained injury and was transported to hospital for assessment.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :